1060 Young Street, Suite 312
Honolulu, Hawaii 96814
Tel: (808) 585-8455 / Fax: (808) 585-8458

Pacific Maxillofacial Center
Oral & Maxillofacial Surgery
Todd K. Haruki, D.D.S., M.D.

FACSIMILE TRANSMITTAL SHEET

To: Linda Sekiya
Fax: 945-7864

Company:
Phone:

From: Susan
Date: June 24, 2003

Subject: Your Patient File

This transmittal consists of ~~12~~ 15 page(s), including this cover sheet.
If you do not receive all of the pages, please call us at (808) 585-8455.

Linda,
Please let us know if we may be of further assistance to you.

Take care,
Susan

EXHIBIT S

Pacific Maxillofacial Center
Oral and Maxillofacial Surgery

Todd K. Haruki D.D.S., M.D.

Main Office Hours MWF 8am-5pm Sat. 8am-12pm
1060 Young Street Suite 312 Honolulu, Hawaii 96814 Tel. (808) 596-8455

Mililani Office Hours Tues 8am-5pm
95-390 Kuahelani Ave. Suite 1A Mililani, Hawaii 96789 Tel. (808) 626-8455

Patient LINDA SEKIYA

Referring Dr. TERRY MATSUMOTO

Reason for referral:

X extraction teeth # 31

____ implant consult

____ cosmetic surgery consult

____ other:

____ treatment/evaluation in the following areas:

Patient has:

____ scheduled with Pacific Maxillofacial Center
on: ___/___/___

____ been advised to call office ASAP

Comments:

Map of locations located on opposite side

Pacific Maxillofacial Center
Oral and Maxillofacial Surgery

Todd K. Harada D.D.S., M.D.

Main Office [illegible]
1000 Young Street Suite 312 Honolulu, Hawaii 96814 Tel. [illegible]

Additional Office [illegible]

Patient Linda Scriffa

Referring Dr. Terry Matsumoto

Reason for referral:

✓ extraction tooth # 31

____ implant consult

____ cosmetic surgery consult

____ other:

____ treatment/evaluation in the following areas:

Patient has:

____ scheduled with Pacific Maxillofacial Center

on / /

____ been advised to call office ASAP

Comments: It doesn't have a dental dentist and asked us to refer.

Map of locations located on opposite side

000292

3

Pacific Maxillofacial Center, Inc.
Todd K. Haruki, D.D.S., M.D.

PATIENT INFORMATION

Welcome to Our Practice!
Thank you for selecting the Pacific Maxillofacial Center. We are committed to providing you with excellent care and will strive to make your visit as pleasant and comfortable as possible. So that we may meet all your healthcare needs, kindly complete this form. If you have any questions or need assistance, please ask us -- we will be happy to help.

Patient Information

Patient: (Miss Ms. (Mrs.) Mr. Dr.) LINDA (First Name) D. (Middle Name) SERIYA (Last Name)

Birthdate: 9/27/46 Nickname or name you prefer to be called by: CUSTY

Sex: (Male (Female)) Marital Status: (Single (Married) Legally-Separated Divorced Widowed)

Social Security #: 575-48-2664 Driver's License #: SAME (If Different from Social Security #) (HI) (State)

Mailing Address: (Street or P.O. Box) (Apt. #) (City) (State) (Zipcode)

Residence Address: 1517 MAKIKI ST (Street) 1201 (Apt. #) HONOLULU, (City) HI (State) 96822 (Zipcode)

Home Phone: 945-7864 Work Phone: — Pager/Cellular: 223-0096

Employer: — Occupation: —

Employer's Address: — (Street) (Suite) (City) (State) (Zipcode)

If Student, School or College: — Status: (Full-Time Part-Time)

Person to Contact in Case of Emergency: LAWRENCE (First Name) SERIYA (Last Name) (HUSBAND) (Person's Relation to You)

Emergency Contact's Home Phone: 945-7864 Emergency Contact's Work Phone:

Dentist: Physician/PCP: DR. MICHAEL T. INADA

Referred by: DR. TERRY MATSUMOTO Are you insured by Kaiser or another HMO? (Yes (No))

Guarantor Information

Person responsible for paying this account: ((Self) Spouse Mother Father Other:)

Method of payment: (Cash Check Visa Mastercard) *If self, please skip the following questions in this section.*

Guarantor: (Miss Ms. Mrs. Mr. Dr.) (First Name) (Middle Name) (Last Name)

Birthdate: / / Social Security #: D.License #: ( ) (If Different from Social Security # / State)

Mailing Address: (Street or P.O. Box) (Apt. #) (City) (State) (Zipcode)

Residence Address: (Street) (Apt. #) (City) (State) (Zipcode)

Home Phone: Work Phone: Pager/Cellular:

Employer: Occupation:

Employer's Address: (Street) (Suite) (City) (State) (Zipcode)

Agreement of Financial Responsibility

I agree to pay in full for all services provided to me (or the named patient). I understand that full payment is required at the time of treatment and any payment plan agreement must be made in writing prior to treatment. If an insurance claim is filed for services, I am responsible for all fees regardless of insurance coverage and will pay any deductible, estimated co-insurance, or fee for non-covered services at the time of treatment. For any balance, a statement will be sent by the 5th of the month and is due before the end of the month. I agree to pay finance charges of 18% per annum (1.5% per month, minimum charge of $2.00) on any past due balance until the account has been paid in full. If collection action is taken, I agree to pay all collection expenses, court costs, and attorney's fees. I will also pay $15.00 for any returned check, and $50.00 for any appointment cancelled without 24 hours notice.

000293

Linda Seriya 12/9/02
Date Guarantor's Signature Date

HEALTH INSURANCE INFORMATION

Pacific Maxillofacial Center, Inc.
Todd K. Haruki, D.D.S., M.D.

Primary Dental Insurance
Insurance Co. & Plan: HMSA Plan F I.D.: F00575482666441 (Member or Policy # on Insurance Card)
Subscriber of Insurance Plan: (Self) Spouse Mother Father Other: ( )
If the subscriber of this plan is either the patient or the guarantor, please skip the following questions in this section:
Subscriber: (Miss Ms. Mrs. Mr. Dr.) ____ (First Name) ____ (Middle Initial) ____ (Last Name)
Mailing Address: ____ (Street or P.O. Box) ____ (Apt. #) ____ (City) ____ (State) ____ (Zipcode)
Home Phone: ____ Work Phone: ____ Employer: ____
Social Security #: ____ Birthdate: / /

Secondary Dental Insurance
Insurance Co. & Plan: ____ I.D.: ____ (Member or Policy # on Insurance Card)
Subscriber of Insurance Plan: (Self Spouse Mother Father Other: ____)
If the subscriber of this plan is either the patient or the guarantor, please skip the following questions in this section:
Subscriber: (Miss Ms. Mrs. Mr. Dr.) ____ (First Name) ____ (Middle Initial) ____ (Last Name)
Mailing Address: ____ (Street or P.O. Box) ____ (Apt. #) ____ (City) ____ (State) ____ (Zipcode)
Home Phone: ____ Work Phone: ____ Employer: ____
Social Security #: ____ Birthdate: / /

Primary Medical Insurance
Insurance Co. & Plan: ____ I.D.: ____ (Member or Policy # on Insurance Card)
Subscriber of Insurance Plan: (Self Spouse Mother Father Other: ____)
If the subscriber of this plan is either the patient or the guarantor, please skip the following questions in this section:
Subscriber: (Miss Ms. Mrs. Mr. Dr.) ____ (First Name) ____ (Middle Initial) ____ (Last Name)
Mailing Address: ____ (Street or P.O. Box) ____ (Apt. #) ____ (City) ____ (State) ____ (Zipcode)
Home Phone: ____ Work Phone: ____ Employer: ____
Social Security #: ____ Birthdate: / /

Secondary Medical Insurance
Insurance Co. & Plan: ____ I.D.: ____ (Member or Policy # on Insurance Card)
Subscriber of Insurance Plan: (Self Spouse Mother Father Other: ____)
If the subscriber of this plan is either the patient or the guarantor, please skip the following questions in this section:
Subscriber: (Miss Ms. Mrs. Mr. Dr.) ____ (First Name) ____ (Middle Initial) ____ (Last Name)
Mailing Address: ____ (Street or P.O. Box) ____ (Apt. #) ____ (City) ____ (State) ____ (Zipcode)
Home Phone: ____ Work Phone: ____ Employer: ____
Social Security #: ____ Birthdate: / /

000294

Release of Records for Insurance
This signature on file is my authorization for the release of my health information, including copies of my dental and medical records, to any health insurance plan or company that provides coverage for me, for the purpose of securing benefits.
X [signature] 12/9/02
Patient's (or Legal Guardian's) Signature — Date

Assignment of Insurance Benefits
This signature on file is my authorization for the payment of medical and dental benefits, otherwise payable to me, to the Pacific Maxillofacial Center directly.
X [signature] 12/9/02
Patient's (or Legal Guardian's) Signature — Date

Pacific Maxillofacial Center
Todd K. Haruki, D.D.S., M.D.

HEALTH HISTORY

Instructions for Completing this Health History
Although oral & maxillofacial surgeons primarily treat the mouth and head, they consider the mutual relationship between the health of these areas and that of the entire body. In order to determine your specific needs and provide you with the best treatment possible, it is important that you complete this health history truthfully and to the best of your ability. Please answer all of the questions below. Your responses will remain confidential.

Patient: (Miss Ms. (Mrs.) Mr. Dr.) LINDA (First Name) D (Middle Name) SEKIYA (Last Name)

Nickname or name you prefer to be called by: CUSTY

Age: 56 Birthdate: 9/27/46 Sex: (Male (Female)) Height: 5'2" Weight: 118

Name of referring dentist or physician: DR. TERRY MATSUMOTO

A. Are you in good health? (Yes) No When was your last physical examination? 9/01

B. Has there been any change in your health over the past year? (Yes) No

C. Are you now under the care of a physician? If so, please describe your condition and list your physician's name:
YES - ANXIETY + DEPRESSION / DR MARK BERNSTEIN
FOOT CONDITION / DR PORTNER

D. Have you had any serious illnesses, operations, or hospitalizations? If so, describe: NO

E. Do you have or have you had any of the following:

1. Congenital heart disease?	Yes (No)	24. Kidney disease?	Yes (No)
2. Damaged heart valves, artificial valves, or heart murmur?	Yes (No)	25. Stomach ulcers or hyperacidity?	(Yes) No
3. Mitral valve prolapse?	Yes (No)	26. Diabetes?	Yes (No)
4. Rheumatic fever or rheumatic heart disease?	Yes (No)	27. Hepatitis, jaundice, or liver disease?	Yes (No)
5. Heart attack, angina (chest pain), or any other heart condition?	Yes (No)	28. Epilepsy or seizures?	Yes (No)
6. Heart surgery or pacemaker?	Yes (No)	29. Psychiatric treatment?	(Yes) No
7. Arteriosclerosis?	Yes (No)	30. Nervousness or anxiety disorder?	(Yes) No
8. High cholesterol?	Yes (No)	31. Abnormal or excessive bleeding?	Yes (No)
9. High / Low blood pressure?	(Yes) No	32. Blood transfusion?	Yes (No)
10. Shortness of breath?	(Yes) No	33. Blood disorder such as anemia or hemophilia?	Yes (No)
11. Stroke?	Yes (No)	34. Cancer or tumors?	Yes (No)
12. Arthritis or painful, swollen joints?	(Yes) No	35. Radiation treatment?	Yes (No)
13. Asthma or bronchitis?	(Yes) No	36. Chemotherapy?	Yes (No)
14. Emphysema?	Yes (No)	37. Artificial joints or joint replacement surgery?	Yes (No)
15. Pneumonia?	(Yes) No	38. Organ transplant?	Yes (No)
16. Tuberculosis?	Yes (No)	39. Any disease, drugs, or operation that has depressed your immune system?	Yes (No)
17. Persistent cough or cough producing blood?	Yes (No)	40. Any other disease or condition not listed above that you think the doctor should know about?	Yes (No)
18. Chronic sinus problems?	Yes (No)	41. Do you wish to talk with the doctor privately about anything?	Yes (No)
19. Thyroid disease?	Yes (No)		
20. Allergies?	(Yes) No	K. For Women Only:	
21. Contact lenses?	Yes (No)	1. Are you pregnant?	Yes (No)
22. Glaucoma?	Yes (No)	2. Are you nursing?	Yes (No)
23. Stiff or sore jaw, clicking or popping of jaw, pain near ear, or difficulty opening mouth?	(Yes) No	3. Are you taking birth control pills?	Yes (No)

000295

Please complete the other side of this health history.

(6)

HEALTH HISTORY

Pacific Maxillofacial Center
Todd K. Haruki, D.D.S., M.D.

L. Are you presently using or taking:

1	Antibiotics or sulfa drugs?	Yes (No)
2	Anticoagulants (blood thinners)?	Yes (No)
3	High blood pressure medicine?	Yes (No)
4	Steroids (Cortisone, etc.)?	Yes (No)
5	Tranquilizers (Valium, etc.)?	(Yes) No
6	Insulin, Diabenese, or similar drug?	Yes (No)
7	Heart Medication (Digitalis, Inderal, Nitroglycerin, Procardia, etc.)?	Yes (No)
8	Marijuana or other recreational drugs?	Yes (No)
9	Diet pills (Fen-Phen, Redux, etc.)	Yes (No)
10	Aspirin or ibuprofen?	(Yes) No
11	Do you smoke or chew tobacco?	Yes (No)
12	Do you drink alcohol?	Yes (No)

M. Are you allergic or have you had a reaction to:

1.	Local anesthetics?	Yes (No)
2.	Penicillin or other antibiotics?	(Yes) No
3.	Sulfa drugs?	? Yes No
4.	Barbiturates, sedatives or sleeping pills?	(Yes) No
5.	Aspirin or ibuprofen?	Yes (No)
6.	Iodine?	Yes (No)
7.	Codeine or other painkillers?	(Yes) No
8.	Latex or rubber products?	Yes (No)
9	Other allergies or reactions?	Yes No

If so, describe: _____

N. Please list the names of all medication you are now taking: XANAX, AMBIEN, PREVACID, CIPRO, TIN

Signature

I understand the importance of an accurate and complete health history, and agree to inform this office of any change in my health status as soon as possible. I certify that the above answers are true to the best of my knowledge.

X _____ 12/9/02 _____

Patient's (or Legal Guardian's) Signature — Date — Doctor's Initials

Health History Update (to be completed at later visit)

A. Has there been any change in your health since your last office visit? Yes No

If so, please describe: _____

B. Are you taking any new medication? Yes No

If so, please list: _____

C. *I have read this health history and confirm that it adequately states my present health condition.*

_____ _____ _____

Patient's (or Legal Guardian's) Signature — Date — Doctor's Initials

Health History Update (to be completed at later visit)

A. Has there been any change in your health since your last office visit? Yes No

If so, please describe: _____

B. Are you taking any new medication? Yes No

If so, please list: _____

C. *I have read this health history and confirm that it adequately states my present health condition.*

000296

_____ _____ _____

Patient's (or Legal Guardian's) Signature — Date — Doctor's Initials

LIST OF ABBREVIATIONS

Ø	no
1°	primary
2°	secondary
A/B	arch bars
A/P	assessment and plan
adj	adjacent
appt	appointment
Ⓑ	bilateral
bg/BG	bone graft
bid	twice a day
bx	biopsy
c̄	with
c/o	complains of
Ca	cancer/carcinoma
CAD	coronary artery disease
CABG	coronary artery bypass graft
carbo	carbocaine
carp	carpule
CGS	chromic gut suture
CHF	congestive heart failure
comp	complications
cont	continue
COPD	chronic obstructive pulmonary disease
CVA	cerebrovascular vascular accident a.k.a. stroke
D — spell out	day
d/w	discussed with
d/w Pt RBA	discussed with patient risks, benefits, and alternatives
diff.	difficult/different
DO	disorder
Dx	diagnosis
EO	extraoral
epi	epinephrine
Etoh	ethanol/alcohol
ext	extract/extraction
F/U	follow up
FOM	floor of mouth
GA	general anesthesia
GERD	gastroesophageal reflux disease a.k.a. heartburn
H&P	history and physical
HA	headache
HBP	high blood pressure
Hep	hepatitis
HTN	hypertension
Hx	histroy
Hyperchol.	hypercholesterolemia
I&D	incision and drainage
IAN	inferior alveolar nerve
IDDM	insulin dependent diabetes mellitus
IMF	intermaxilliary fixation
Infxn	infection

IO	intraoral
IV	intravenous
Ⓛ	left
lido	lidocaine
ⓜ	heart murmur
Med	medication
MI	myocardial infarction a.k.a. heart attack
min	minimal
MIO	maximal incisal opening
MN	midnight
mod	moderate
MPF	mucoperiosteal flap
MVA	motor vehicle accident
MVP	mitral valve prolapse
N2O	nitrous oxide
NaCl H2O	salt water
NIDDM	non-insulin dependent diabetes mellitus
NKDA	no known drug allergies
nl	normal
NPO	nothing by mouth (*nil per os*)
NS	normal saline
NSF	no significant findings
O/P	oropharynx
OAC	oroantral communication
OH	oral hygiene
op	operation/operative
p̄	after
p-cor	pericoronitis
PA	periapical (film)
pano	panorex film
PARL	periapical radiolucency
Path	pathology
PCN	penicillin
PE	physical exam
Pen VK	penicillin VK
PMHx	past medical history
PO	by mouth (*per os*)
POIG	pre-operative instructions given
POPPDA	partial or permanent paresthesia, dysesthesia, anesthesia
PPD	packs of per day
prn	as often as needed (*pro re nata*)
Proc	procedure
Pt	patient
Pt understands RBAs	patient understands risks, benefits, and alternatives
PUD	peptic ulcer disease
q	every
qD	once a day
qid	four times per day
Ⓡ	right
R&B	risks and benefits
RBA	risks, benefit, and alternatives
ROS	review of systems

000298

9

RTO	returns to office
Rx	prescription
s̄	without
S/Sx	signs and/or symptoms
S/P	after (*status post*)
SBE	subacute bacterial endocarditis
SCCa	squamous cell carcinoma
SL	sublingual
SM	submandibular
SOB	shortness of breath
surg	surgical
T3	Tylenol #3
TB	tuberculosis
TIA	transient ischemic attack (mini-stroke)
tid	three times per day
TMJ	temporomandibular joint
TOB	tobacco
TOPHDA	temporary or permanent hypesthesia, dysesthesia, anesthesia
TTP	tender to palpation
Tx	treatment
wk	week
WNL	within normal limits
y/o	years old

7 < without greater than less than

no dark marks

Pacific Maxillofacial Center, Inc.
Todd K. Haruki, D.D.S., M.D.

RECORD OF TREATMENT

Patient's Name: Linda D. Sekiya "Custy"

Date	Treatment Notes
DEC - 9 2002	56 y/o F referred by Dr T. Masunaga for eval #31
	Pt c/o pain for #31 ē temp (warm) and chewing; Pt request LA ō
	PMHx ROS ATN; Hyperlipidemia, asthma, colitis
	anxiety D/O
	Meds: Xanax; Ambien, Prevacid, Elavil
	Allergies: PCN - N/V; edema, SOB
	Codeine - erratic nausea
	ØTOB
	PE: #31 TTP: large filling
	PA: #31 s̄ RCT
	[redacted], RBAs also pt understanding TOPUDA; ordy tooth
	damage, retained root tips, etc. Pt understands RBAs
	Proc: 4% art ō epi x 2 carp; 50% N2O @ 6 LPM
	MPF reflected around #31; buccal bone removed;
	#31 LOD s̄ comp
	100% O2 @ 6 LPM x 5 min p̄ proc completed
	Rx Ø
	F/u Tak — [signature]
DEC 16 2002	S c/o
	PE ext site granulating in. Pt d/s infection
	A/P healing WNL
	F/u prn
	[signature]

000300

(11)

Todd K. Haruki, DDS, MD
Pacific Maxillofacial Center, Inc.
1060 Young Street, Suite 312, Honolulu, HI 96814

Name: Linda Sekiya
Please return film to: Date: 12-9-02

Pacific Maxillofacial Center
1060 Young Street, Suite 312
Honolulu, Hawaii 96814

SekiyaLinda

Pacific Maxillofacial Center, Inc.
Todd K. Haruki, DDS, MD

Informed Consent Discussion for Oral & Maxillofacial Surgery

I am being provided this information and consent form so that I may better understand my condition and the treatment recommended for me. Before beginning, I want to be provided with enough information, in a way I can understand, to make a well and informed and confident decision regarding my proposed treatment.

1. My condition has been explained to me as:

   Non-restorable tooth #31

2. This is my consent for Dr. Todd K. Haruki and his assistant(s) to treat my condition with the following procedure(s):

   Removal of tooth #31

3. I understand that there may be alternate forms of treatment including no treatment at all. The risks and benefits of these choices have been presented to me.

4. I understand that there are inherent and potential risks and side effects associated with my proposed treatment plan including, but not limited to:

   A. Post-operative swelling, bruising, and discomfort in the surgery area(s) that may require several days of at-home recovery.
   B. Prolonged or heavy bleeding that may require additional treatment.
   C. Injury to adjacent teeth or dental restorations (i.e. fillings, crowns, etc).
   D. Post-operative infection that may require additional treatment.
   E. Stretching of the corners of the mouth that may cause cracking or bruising, and may heal slowly.
   F. Restricted mouth opening during healing; sometimes related to swelling and muscle soreness, and sometimes related to stress on the jaw joints (TMJ), especially when TMJ problems already exist.
   G. A decision to leave a small piece of root in the jaw when its removal would require extensive surgery or risk other complications.
   H. Fracture of the jaw.
   I. Injury to the nerve underlying lower teeth, resulting in pain, numbness, tingling or other sensory disturbances in the chin, lip, cheek, gums or tongue and may persist for several weeks, months or, in rare instances, permanently.
   J. Opening of the sinus (a normal chamber situated above the upper teeth) requiring additional surgery or treatment.
   K. Dry socket (loss of blood clot from the extraction site).
   L. Allergic reactions (previously unknown) to any medications used treatment.
   M. Sharp ridges or bone splinters may form later at the edge of the socket. These usually require another surgery to smooth or remove.

5. I understand that, during the course of my treatment, unforeseen conditions may be revealed that may require changes in the procedure(s) noted in paragraph 2 above. I authorize Dr. Haruki and his staff to use professional judgment to perform such additional procedures that are necessary and desirable to complete my surgery.

Pacific Maxillofacial Center, Inc.
Todd K. Haruki, DDS, MD

6. The anesthetic I have chosen for my surgery is:
   ___ Local anesthesia;
   ___✓ Local anesthesia with nitrous oxide/oxygen inhalation sedation;
   ___ Local anesthesia with intravenous sedation;
   ___ Local anesthesia with general anesthesia.

7. I understand that anesthetic risks include: discomfort, swelling, bruising, infection, prolonged numbness and allergic reactions. There may be inflammation at the site of an intravenous injection (phlebitis) that may cause prolonged discomfort and/or disability and may require special care. Nausea and vomiting, although uncommon, may be unfortunate side effects of IV anesthesia. I understand that intravenous anesthesia is a serious medical procedure and although considered very safe, does carry with it rare risks of heart attack, brain damage or even death.

8. My obligations if intravenous sedation or general anesthesia is used:
   A. Because anesthetic medications cause prolonged drowsiness, a responsible escort must bring me to the office, take me home, and stay with me until I have sufficiently recovered to care for myself. This may take up to 24 hours.
   B. **I may not have anything to eat or drink for eight (8) hours prior to my anesthestic. I understand that *to do otherwise may be life-threatening*.**
   C. It is important, however, that I take any regular medications (high blood pressure medicine, antibiotics, etc.) using only a small sip of water.
   D. During my recovery period (24 hours after surgery), I must not drive a car or operate machinery or power tools. I should avoid making important decisions such as signing legal documents, etc.

9. No guarantee or assurance has been given to me that my proposed treatment will be curative and/or successful to my complete satisfaction. I understand that due to individual patient differences, there exists a risk of failure, relapse, selective retreatment, or worsening of my present condition despite the care I have been provided.

10. I have had an opportunity to discuss with Dr. Haruki my past medical and health history including any serious problem and/or injuries.

11. I agree to cooperate completely with the recommendations of Dr. Haruki while I am under his care, realizing that failure to follow recommendations and post-operative instructions could result in a less than optimal outcome.

I have received information about my proposed treatment. I have discussed my treatment with Dr. Haruki and have been given an opportunity to ask questions and have them fully answered. I understand the nature of the recommended treatment, alternate treatment options, and the risks of my recommended treatment. **I wish to proceed with the recommended treatment.**

X _____ 12/9/02
Patient's (or Legal Guardian's) Signature — Date

_____ 12/9/02
Witness' Signature — Date

_____ 12/9/02
Doctor's Signature — Date

Pacific Maxillofacial Center, Inc.
Oral & Maxillofacial Surgery
Todd K. Haruki, D.D.S., M.D.

December 9, 2002

Terry S. Matsumoto, DMD
848 S. Beretania Street, Suite 301
Honolulu, HI 96813

Regarding: Linda D. Sekiya

Dear Dr. Matsumoto:

Thank you for your referral of Mrs. Linda Sekiya. I had the pleasure of seeing her on December 9, 2002. The following procedure was performed:

Removal of tooth #31

Linda was a very nervous, but cooperative patient who did very well with local anesthesia and nitrous oxide/ oxygen inhalation sedation. She will be in touch with us for normal post-operative care.

Thank you again, Terry, for the opportunity to participate in Linda Sekiya's care. My staff and I consider it a privilege to care for your patients, and we appreciate your confidence.

Sincerely,

Todd K. Haruki, DDS, MD

Enc.: 1 PA

Main Office: 1060 Young Street, Suite 312, Honolulu, Hawaii 96814
Mililani Office: 95-390 Kuahelani Avenue, Suite 1A, Mililani, Hawaii 96789
tel. (808) 593-0155 Fax. (808) 585-8458